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Office of Administrative Law Judges
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Issue Date: 09 February 2006

Case Nos.: 2005-BLA-5029
2005-BLA-5030

In the Matter of:

Phyllis A. Kilgore, Widow of
Gary Kilgore,
Claimant

v.

Blackhawk Mining Company,
Employer

And

Director, Office of Workers' Compensation
Programs,
Party-In-Interest

DECISION AND ORDER
DENYING BENEFITS IN LIVING MINER'S AND SURVIVOR'S CLAIMS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901 et seq. In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

This matter was scheduled for hearing on September 14, 2005. On June 28, 2005, Phyllis Kilgore (hereinafter "the Claimant"), through counsel, submitted a Motion to Waive Hearing and Submit the Case on the Record. On July 11, 2005, Blackhawk Mining (hereinafter "the Employer") submitted a letter stating that it had no objection to the Claimant's request. On July 15, 2005, I issued an Order Canceling Hearing Establishing Schedule for Submission of Evidence on July 15, 2005; on November 30, 2005, I issued an Order Closing the Record and Establishing a Briefing Schedule. The Employer submitted a Brief on December 28, 2005; the Claimant submitted a brief on December 30, 2005.

I have based my analysis on the entire record, including the exhibits, submitted briefs, and representations of the parties, and given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

Jurisdiction and Procedural History

Mr. Kilgore filed a claim for benefits on April 26, 2001; he died on March 11, 2003. On April 3, 2003, the Director issued a Proposed Decision and Order awarding benefits, finding that the Claimant had established totally disabling pneumoconiosis and that Blackhawk Mining was the responsible operator. (DX 34) On April 10, 2003, the Employer requested a hearing with the Office of Administrative Law Judges. (DX 36) However, the Director held the case file in abeyance pending issuance of a Proposed Decision and Order in the Claimant's survivor claim.

The Claimant is Mr. Kilgore's wife; she filed a claim for benefits as his survivor on April 22, 2003. The Director issued a Proposed Decision and Order denying benefits on June 18, 2004. While the Director found that Mr. Kilgore had contracted pneumoconiosis caused by his coal mine work, the Director concluded that the evidence was not sufficient to establish that pneumoconiosis contributed to his death.

By letter dated June 22, 2004, the Claimant requested a hearing with the Office of Administrative Law Judges; Claimant's counsel also requested a hearing by letter dated July 16, 2004. By letter dated July 22, 2004, Claimant's counsel also requested that Mr. Kilgore's living miner's claim be forwarded to the OALJ. Both cases were forwarded to this office on September 30, 2004 and subsequently assigned to me.

Mr. Kilgore filed a previous claim for benefits on June 25, 1991, which was denied by the Director on December 16, 1991. (DX 1). Mr. Kilgore requested a hearing with the Office of Administrative Law Judges, and on May 3, 1993, Administrative Law Judge Bernard Gilday issued a Decision and Order denying benefits. Judge Gilday determined that Mr. Kilgore had established over eleven years of coal mine employment, but that he did not prove that he had pneumoconiosis or a totally disabling pulmonary impairment.

Issues

The issues contested by the Employer in connection with the living miner's claim are:

1. Whether the Claimant has established that Mr. Kilgore had pneumoconiosis.
2. If so, whether Mr. Kilgore's pneumoconiosis was due to his coal mine employment.
3. Whether Mr. Kilgore was totally disabled.
4. If so, whether Mr. Kilgore's totally disabling respiratory condition was due to pneumoconiosis.
5. Whether the evidence establishes a material change in condition.

In connection with the survivor's claim, in addition to the issue of whether Mr. Kilgore had pneumoconiosis due to his coal mine employment, the Employer disputes that Mr. Kilgore's death was due to pneumoconiosis.

Stipulations

The Employer has stipulated that Mr. Kilgore worked in coal mines for 11.25 years, based on Judge Gilday's determination in Mr. Kilgore's previous claim. Brief for Employer, at 5, n. 6.

Findings of Fact and Conclusions of Law

Background

Mr. Kilgore married his wife, Phyllis Kilgore (nee Griffey) on March 31, 1973. (DX 13 and 45) They had one child together, Larry Dwayne Kilgore, but he was not a dependent at the time Mr. Kilgore filed his claim. (DX 3 and 14)

In his living miner's claim, Mr. Kilgore alleged 14 years of coal mine employment. (DX 3) His last coal mine employment job duties included using a bulldozer to push coal to loadout feeders, piling coal, operating a locomotive engine to load coal cars, and working at the tipple. (DX 5)

Living Miner's Claim

In connection with Mr. Kilgore's living miner's claim, the parties submitted the following evidence, in accordance with the limitations of the new guidelines.

X-ray Evidence[1]

Exhibit No.	*Date of X-ray*	*Reading Date*	*Physician/ Qualifications*	*Impression*
DX 50-490	2/2/99	2/2/99	Simpson	Borderline heart size. Vascularity and interstitial markings diffusely prominent.
DX 53	9/1/00	9/1/00	Savolaine	Increased interstitial reticular markings, peribronchial cuffing consistent with chronic bronchial disease, small granuloma in right lower hilar area.

[1] B-B reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

DX 18-8	4/17/01	4/17/01	Potter	q/s, 4 zones, 1/1
DX 18-7	4/17/01	5/16/01	Sundaram	q/s, 4 zones, 2/2
DX 19	4/17/01	8/7/01	Halbert / BCR, B	Negative for pneumoconiosis
DX 16	6/11/01	6/11/01	Wicker	s/t, 4 zones, 1/1
DX 17	6/11/01	7/31/01	Sargent / BCR, B	Quality reading
DX 20	8/16/01	8/16/01	Westerfield / B	t/q, 6 zones, 1/1
DX 53	1/9/02	1/9/02	Sola	COPD changes, linear atelectasis, infiltrative process in left lower lobe. Fullness in region of left hila with strong suspicion for mass.
DX 50-390	1/10/02	1/10/02	Patsey	Suspicious left lung mass, superimposing left hilum; mild bibasilar atelectasis and chronic interstitial changes.
DX 50-394	1/11/02	1/11/02	Rice	Left hilar mass, small left pneumothorax. Right lung chronic pulmonary change.
DX 50-395	1/12/02	1/12/02	Stevens	Small left pneumothorax, spears smaller than yesterday. Small amount of left pleural fluid. Left hilar mass. Ill-defined somewhat nodular abnormality in lateral left mid to lower lung field. Mild atelectasis right medial lung base.
DX 52 DX 50-81	1/21/02	1/21/02	Poulos	5.5 cm left perihilar mass
DX 50-82	3/4/02	3/4/02	Halbert / BCR, B	Chest appears much improved with resolution of adenopathy and infiltrate on left.
DX 53	8/13/02	8/13/02	Sola	Mass in region of left hilum. Minor obstructive changes in left lung.
DX 50-4	9/5/02	9/5/02	Halbert / BCR, B	Apparent developing mass in left hilum with associated infiltrate in perihilar area.
DX 50-5	10/14/02	10/14/02	Kendall	No change in left hilar mass, left perihilar infiltrate appears to have resolved.
DX 50-8	11/19/02	11/19/02	Halbert/BCR, B	No change in mass or adenopathy in left hilum with associated mild infiltrate.

DX 52-26	12/30/02	12/30/02	Poulos	Stable mass in left hilum with small area of infiltrate in lingular segment of left upper lobe.
DX 50-214	1/16/03	1/17/03	Sola	Compared to 8/13/02, left hilum mass tripled in size. New obstructive pneumonia adjacent to left hilar mass.
DX 50-283	2/3/03	2/3/03	Narra	Mass in left perihilar region appears less prominent. However, more volume loss in left lung with hazy opacity, most likely related to obstructive pneumonitis secondary to neoplasm.
DX 51-25 DX 50-193	2/5/03	2/5/03	Kendall	Left hilar mass with mild diffuse left-sided infiltrate and mild pleural thickening in left apex, new from prior exam. Small right basilar infiltrate.
DX 50-325	3/7/03	3/9/03	Sola	Significant COPD changes, several bullae in lower lobes, thickened fissures, left hilar mass with adjacent areas of small patchy hazy opacities which could be related to obstructive pneumonia. Patchy infiltrate in left lung seems less than before.

CT Scan Evidence

Exhibit No.	***Date of Scan***	***Reading Date***	***Physician/ Qualifications***	***Impression***
CX 14, DX 53	1/9/02	1/9/02	Dr. Sola	Changes suggestive of COPD. Bilateral pleural fluid in dependent portion of lungs. Infiltrate in right lung not seen in plain films. Infiltrate in left mid lung seen in chest films. Fullness and mass density in left hilum which could be inflammatory or from neoplastic process of which later is to be excluded by bronchoscopy.

CX 5 DX 50-391	1/11/02	1/14/02	Dr. Stevens	Left hilar mass, 2 x 2.5 cm anterior to the primary division of the left bronchus; component posterior to the bronchus of similar size. Highly suspicious for malignancy. Pulmonary infiltrate in left midline region laterally, small bibasilar infiltrates. 2cm high density in posterior aspect of dome of right lobe of liver, suspicious for metastatic focus.
DX 50-79	1/31/02	1/31/02	Dr. Kendall	Enhancing lesions within dome and along capsule of right lob of liver that likely represent hypervascular metastases.
DX 52-32	3/4/02	3/4/02	Dr. Halbert / BCR, B	Much improved with resolution of adenopathy and infiltrate on left.
DX 52-33	4/17/02	4/17/02	Dr. Kendall	Minimal left perihilar scarring, lungs otherwise clear.
DX 52-29	4/17/02	4/17/02	Dr. Kendall	1 cm area of soft tissue density within left hilum, may represent residual tumor or fibrosis. Small mediastinal nodes measuring less than 1 cm in size with left perihilar scarring.
DX 50-3	9/4/02	9/4/02	Dr. West	CT of abdomen. Stable hepatic nodules.
DX 50-6	11/21/02	11/21/02	Dr. Kendall	CT of abdomen: Fatty infiltration of liver with multiple metastases, appear unchanged. Right renal cyst.
DX 50-7	11/21/02	11/21/02	Dr. Kendall	Stable mediastinal and left hilar adenopathy with small lingular infiltrate.
DX 50-6	11/21/02	11/21/02	Dr. Kendall	Fatty infiltrate of liver with multiple metastases. Appear unchanged from prior exam. Right renal cyst.
DX 52-24	11/29/02	11/30/02	Dr. West	No evidence of central pulmonary embolism and no definite peripheral emboli detected. Bulky adenopathy, especially at left hilum and mediastinum resulting in constriction of left upper lobe artery, vein, and bronchus. Small patchy infiltrates seen at lingual and right middle lobe.
DX 50-215	1/19/03	1/19/03	Sola	Obstructive atelectasis left upper lobe with a left hilar mass tripled in size compared to previous exam. Liver mets.

Pulmonary Function Studies

Exhibit No.	***Date***	***Age/Ht***	***FEV1***	***FVC***	***MVV***	***Effort***	***Qualifying[2]***
DX 18	5/16/01	-	2.37	2.79	70.6	-	No
DX 16	6/11/01	51 / 67"	2.52	3.18	84.36	Good	No
DX 20	8/16/01	51 / 67"	2.59 2.71*	3.35 3.41*	63 91*	Good	No
DX 22	1/11/02	51 / 66"	1.75	2.05	-	-	Yes

* After administration of bronchodilators

Arterial Blood Gas Studies

Exhibit No.	***Date***	***Physician***	***pCO2 (rest)***	***pO2 (rest)***	***Qualifying[3]***
DX 16	6/11/01	Wicker	33.0	79.7	No
DX 20	8/16/01	Westerfield	34	81	No
DX 22	1/10/02	Khalil	31.8	61.9	Yes

Medical Opinions

Dr. Raghu Sundaram

Dr. Sundaram examined Mr. Kilgore on May 16, 2001. (DX 18) Mr. Kilgore reported over 14 years of coal dust exposure and a current smoking habit of a half-pack a day. He presented with shortness of breath. Dr. Sundaram obtained a chest x-ray and pulmonary function tests. Mr. Kilgore's chest x-ray showed pneumoconiosis, with a 2/2 perfusion; his pulmonary function tests revealed a pulmonary impairment.

[2] A "qualifying" pulmonary function study yields values that are equal to or less than the appropriate values set out in the tables at 20 C.F.R. Part 718, Appendix B. A "non-qualifying" study exceeds those values. 20 C.F.R. §718.204(b)(2)(i).

[3] A "qualifying" arterial blood gas study yields values that are equal to or less than the appropriate values set out in the tables at 20 C.F.R. Part 718, Appendix C. A "non-qualifying" study exceeds those values. 20 C.F.R. §718.204(b)(2)(ii).

Dr. Sundaram diagnosed coal worker's pneumoconiosis due to coal dust exposure. He attributed Mr. Kilgore's pulmonary impairment to prolonged exposure to coal dust. Dr. Sundaram felt that Mr. Kilgore could not perform his usual coal mine employment or comparable work in a dust-free environment due to his shortness of breath with limited activity.

Dr. Sundaram wrote a letter dated March 19, 2003 , in which he reported that he had treated Mr. Kilgore for several years for coal workers' pneumoconiosis and chronic obstructive pulmonary disease with exacerbation. He stated that Mr. Kilgore was later diagnosed with bronchogenic carcinoma. (DX 49-a)

According to Dr. Sundaram, Mr. Kilgore's work history consisted of several years in the coal mines, with prolonged exposure to coal dust. Mr. Kilgore's radiological data, pulmonary function tests, work history, and clinical data all supported a diagnosis of coal workers' pneumoconiosis. Dr. Sundaram concluded that Mr. Kilgore's exposure to coal dust contributed to his death.

Dr. Mitchell Wicker, Jr.

Dr. Wicker examined Mr. Kilgore on June 11, 2001 on behalf of the Department of Labor. (DX 16) He recorded Mr. Kilgore's employment history and medical history, noting his past pneumonia, arthritis and heart disease. Dr. Wicker performed a chest x-ray, pulmonary function tests, and arterial blood gas studies.

Mr. Kilgore's complaints included sputum production, wheezing, dyspnea, cough, orthopnea, chest pain, and paroxysmal nocturnal dyspnea. On physical examination, Dr. Wicker noted decreased breath sounds and bibasilar rhonchi to auscultation. Mr. Kilgore's chest x-ray showed no acute pulmonary disease, but Dr. Wicker saw increased markings at both bases consistent with chronic bronchitis. He also noted pneumoconiosis 1/1, s, t, involving both lower lung fields.

Dr. Wicker concluded that there was no evidence of pneumoconiosis or an occupational lung disease caused by coal mine employment. As he found no respiratory impairment, he felt that Mr. Kilgore's respiratory capacity was sufficient to allow him to return to coal mine employment.

Dr. B.T. Westerfield

Dr. Westerfield, who is board-certified in internal and pulmonary medicine and a B reader, examined Mr. Kilgore on August 16, 2001. (DX 20) Dr. Westerfield also testified by deposition on April 18, 2003. (DX 52) Mr. Kilgore reported shortness of breath with exertion, cough, and sputum production. His medical history included pneumonia, but no history of tuberculosis. He also had a history of cardiac disease, and reported a past heart attack and coronary angioplasty.

Mr. Kilgore indicated that he began smoking cigarettes at age 21; at the time of this appointment, he smoked approximately a half-pack a day. Mr. Kilgore reported 14-17 years of coal mine employment.

On physical examination, Mr. Kilgore's lungs were clear to auscultation and percussion. Dr. Westerfield reported that the x-ray revealed opacities consistent with pneumoconiosis. His

pulmonary function tests and arterial blood gas studies were normal; his carboxyhemoglobin level was elevated to 4.1, indicating a continuous smoking habit.

Dr. Westerfield also reviewed the results of Dr. Sundaram's spirometry performed on May 16, 2001, and Dr. Puram's spirometry performed on January 16, 2002. Dr. Westerfield concluded that both tests were invalid. He pointed out that at least three spirometry maneuvers are required, with the best two FVCs and FEV1s being within a 5% variability. Neither test met these requirements. Dr. Westerfield also pointed out that Dr. Sundaram used incorrect predicted values, making the percent predicted results lower than what is in the Knudson tables.

Dr. Westerfield concluded that Mr. Kilgore had a history of exposure to coal dust, shortness of breath on exertion, a history of cigarette smoking, and a history of coronary artery disease. He diagnosed simple pneumoconiosis based on Mr. Kilgore's positive x-ray, and determined that coal dust inhalation was the cause. He found no respiratory impairment during his examination, but he did see a decrease in lung function in later tests. He attributed this decrease in lung function to Mr. Kilgore's lung cancer or treatment, but found no evidence suggesting that his pneumoconiosis affected his lung cancer. He felt that Mr. Kilgore's development of lung cancer between the time of the two tests supported his opinion. Dr. Westerfield believed that Mr. Kilgore could perform his last coal mining job at the time of his appointment.

Treatment Records

Pikeville Methodist Hospital (PMH)

On January 18, 2002, Dr. Puram visited Mr. Kilgore at Pikeville Methodist Hospital for a small cell lung cancer consult. (CX 9, DX 51, DX 50-112) Mr. Kilgore reported that in 1985, he was poisoned with anti-freeze, and since then had precordial chest pain. He thought it could be related because the chest pain he was experiencing was the same kind. Mr. Kilgore reported asbestos and coal dust exposure; he had quit smoking two weeks earlier. His medical history included spleen removal, bowel obstruction, hernia repair, and stent placement.

Mr. Kilgore had a headache, cough, shortness of breath, chest pain, and some abdominal pain. He appeared anxious, but not in acute distress. Dr. Puram diagnosed small cell lung cancer, coronary artery disease, chronic obstructive pulmonary disease, and coal worker's pneumoconiosis.

On January 28, 2002, Dr. Puram again saw Mr. Kilgore at the hospital. (DX 51, DX 50-114) He noted that Mr. Kilgore had received his first cycle of chemotherapy and was doing well. On examination, Mr. Kilgore had diminished breath sounds. Dr. Puram concluded that Mr. Kilgore was tolerating therapy.

On February 11, 2002, Dr. Puram examined Mr. Kilgore and again found diminished breath sounds. (DX 51, DX 50-115) He noted that Mr. Kilgore had extensive small cell carcinoma, and planned to continue another cycle of VP-16 and carboplatin.

On March 4, 2002, Mr. Kilgore saw Dr. Puram after completing two cycles of carboplatin and VP-16 without any significant problem. (DX 51, DX 50-116) Mr. Kilgore's examination revealed alopecia, and his chest x-ray showed significant improvement. Dr. Puram concluded that Mr. Kilgore's extensive small cell carcinoma had responded to chemotherapy.

Dr. Puram admitted Mr. Kilgore to PMH on April 8, 2002 for treatment of his lung cancer. (DX 50-137) He was followed by Drs. Timothy Wright and Tamara L. Musgrave. (DX 50-138, DX 50-140) Mr. Kilgore complained of progressive weakness and progressively lower blood counts; he was on a chemotherapy regimen of carboplatin and VP-16. He also had liver metastasis from small cell carcinoma. Mr. Kilgore's medical history included coronary artery disease with stent, hyperlipidemia, gastritis, chronic obstructive pulmonary disease, and black lung.

On physical examination, Mr. Kilgore had decreased breath sounds. Dr. Wright diagnosed him with anemia, thrombocytopenia, small cell lung cancer, coronary artery disease, chronic obstructive pulmonary disease, and coal worker's pneumoconiosis. He planned to admit Mr. Kilgore for care by Dr. Puram. Dr. Musgrave diagnosed pancytopenia, secondary to chemotherapy. She suggested continuing Procrit and transfusing 2 units of packed red blood cells and 1 unit of free platelets.

On April 15, 2002, Dr. Puram followed up with Mr. Kilgore after four chemotherapy cycles and a transfusion. (CX 51) Mr. Kilgore felt stronger; his examination was unremarkable.

On April 19, 2002, Dr. Puram followed up with Mr. Kilgore, noting that he tolerated four cycles of chemotherapy well. (DX 51, DX 50-119) A CAT scan of the chest showed that the chest lesion had disappeared, but the liver had not changed. Dr. Puram was unsure whether these findings represented metastatic disease. Mr. Kilgore's physical examination was unremarkable. Dr. Puram noted that Mr. Kilgore had extensive small cell with questionable liver metastases, unchanged with chemotherapy.

Dr. Puram followed up with Mr. Kilgore on April 22, 2002. (DX 50-118) He increased Mr. Kilgore's Ultram and planned to see him after his bone scan. He followed up with Mr. Kilgore on June 10, 2002, when he reported feeling significantly better (DX 51-13, DX 50-123) Physical examination revealed diminished breath sounds and breast tenderness, probably suggesting hyperproloactinemia. Dr. Puram determined that his carcinoma of the lung was stable and advised using hot compresses.

Dr. Modur saw Mr. Kilgore on May 13, 2002 at PMH of Kentucky for a radiation consultation at Dr. Puram's request. (DX 50-120) Dr. Modur noted Mr. Kilgore's extensive small cell lung cancer and liver metastases. Mr. Kilgore's CT scan of the chest showed that the tumor in his lung had disappeared, but his liver had lesions consistent with metastatic disease. However, these lesions did not show up on a PET scan. Dr. Modur noted that Mr. Kilgore's medical history included a heart attack with stent placement, arthritis, black lung disease, splenectomy, abdomen abscess, and hernia repair. Mr. Kilgore had shortness of breath, but denied any serious cough or hemoptysis. A physical examination showed fair air entry in both lungs. Dr. Modur noted that if Mr. Kilgore's left lung lesion had to be radiated, some of his coronary artery would also be radiated, possibly aggravating problems with his coronary artery disease. He recommended that if radiation were not a possibility, that Mr. Kilgore should be followed closely by Dr. Puram. He also noted Mr. Kilgore's abnormal liver profiles.

On May 20, 2002, Dr. Modur learned from the liver ultrasound results that the abnormalities in Mr. Kilgore's liver were not metastatic disease. (DX 50-122) He recommended that Mr. Kilgore receive radiation for his lung cancer.

Dr. Puram saw Mr. Kilgore on August 7, 2002. (DX 51-14, DX 50-124) At that time, Mr. Kilgore did not want to go through radiation, because he was feeling okay. On examination, he had diminished breath sounds. Lab data indicated an elevated triglyceride marker. Dr. Puram diagnosed small cell carcinoma of the lung and hyperlipidemia.

On August 20, 2002, Mr. Kilgore presented with chest pain on the left side. (DX 51-15, DX 50-125) A chest x-ray revealed possible progression. Dr. Puram compared the chest x-ray to a film taken in April, noting possible slight worsening. He advised ruling out recurrence with a CAT scan.

On August 26, 2002, Mr. Kilgore returned to Dr. Puram and was notified that his CAT scan showed recurrence. (DX 51-16, DX 50-126) He reported improvement in pain level, and he had mildly elevated "LFTs." On physical examination, Mr. Kilgore had diminished breath sounds and some chest wall tenderness. Dr. Puram considered doing a PET scan.

On September 1, 2002, Dr. Puram saw Mr. Kilgore for a follow-up. (DX 51-17, DX 50-127) A PET scan showed only chest involvement, but a CAP scan of the abdomen revealed some change in the nodules in the liver. Physical examination revealed diminished breath sounds.

On September 4, 2002, Dr. West performed a CT scan of Mr. Kilgore's abdomen, noting stable hepatic nodules. (DX 50-3)

Mr. Kilgore returned to Dr. Puram on September 13, 2002, after receiving 12 cycles of topotecan. (DX 51-18, DX 50-128) Physical examination revealed diminished breath sounds in his lungs. On September 23, 2002, Dr. Puram again saw Mr. Kilgore for complaints of nausea after he had received two cycles of chemotherapy. (DX 51-21, DX 50-129) Physical examination revealed occasional rhonchi in Mr. Kilgore's lungs.

On October 14, 2002, Mr. Kilgore complained of chest pain, as well as weakness and tiredness. (DX 51-20, DX 50-130) Dr. Puram's chest x-ray revealed no changes in the left hilar mass. He felt that Mr. Kilgore was stable.

On November 4, 2002, Mr. Kilgore complained of right-sided chest pain. (DX 51-19, DX 50-131) He also felt weak and tired. On physical examination, Dr. Puram noted occasional rhonchi. On November 19, 2002, Mr. Kilgore complained of increased pain. (DX 51-22, DX 50-132) Dr. Puram noted that he had been mostly pleuritic on the right side; he noted shortness of breath and diminished lung sounds. A chest x-ray revealed no change in the left hilum.

On December 2, 2002, Mr. Kilgore presented with complaints of significant pleuritic pain and shortness of breath. (DX 51-23, DX 50-133) A pulmonary spiral CT scan was negative for PE and showed no significant change. Dr. Puram noted that Mr. Kilgore's heart function had diminished. On physical examination, Dr. Puram found Mr. Kilgore's lungs to have diminished breath sounds.

On December 30, 2002, Dr. Puram reported that Mr. Kilgore had finished Topotecan with no significant worsening of his condition. (DX 51-24, DX 50-134) On this visit, Mr. Kilgore complained of a headache. A physical examination revealed occasional rhonchi in his lungs; a chest x-ray showed no significant change. Dr. Puram diagnosed small cell lung carcinoma and possible bronchitis.

Mr. Kilgore visited Dr. Puram on January 20, 2003, for an oncology follow-up. (DX 51, DX 50-135) He had been off therapy but his chest pain had increased. On physical examination, Mr. Kilgore had chest pain and occasional rhonchi. Dr. Puram noted that Mr. his chest x-ray showed progression, and he advised using Taxol and Camptosar weekly.

Mr. Kilgore was admitted to PMH on February 4, 2003 for neutropenia, fever, severe diarrhea, and chest pain. (DX 50-157) He was examined by Dr. Puram, who found that he had very little air entry on the right side, and rhonchi on the left. His abdomen was grossly distended, and he had lower left quadrant tenderness. Dr. Puram prescribed Neupogen and Fortaz. Dr. Gutti consulted for pain control, and Dr. Naqvi consulted for hypernatremia. His chest x-ray and neutropenia improved. Mr. Kilgore was discharged to home February 13, 2003 with home oxygen and nebulizer treatments. He was advised to drink significant fluids and return to the clinic. His prognosis was poor despite the improved chest x-ray.

On February 6, 2003, Dr. West took an x-ray of Mr. Kilgore's thoracic and lumbar spine. (DX 50-2). He noted no fractures, subluxations or bone destruction. Dr. Puram visited Mr. Kilgore on February 20, 2003 at the PMH. (CX 8, DX 51, DX 50-136) He noted his recurrent small-cell carcinoma, and that he was admitted with neutropenia and pneumonia with significant pain. Mr. Kilgore reported shortness of breath with even minimal exertion, and weight loss. Physical examination revealed occasional rhonchi. Dr. Puram diagnosed recurrent small-cell lung cancer, diabetes mellitus and respiratory failure.

Central Baptist Hospital (CBH)

On February 2, 1999, Mr. Kilgore was admitted to GBH for a heart attack he experienced after lifting some heavy oxygen tanks. (DX 50-455) Physical examination revealed decreased but clear breath sounds. Dr. Avichai Eres diagnosed a heart attack, heavy tobacco abuse, history of severe hypertriglyceridemia, and pneumoconiosis or chronic obstructive pulmonary disease. He performed a left heart catheterization, left ventriculography, selective coronary angiography, intravenous administration of ReoPro, stent deployment to the right coronary artery, and intracoronary administration of nitroglycerin and Cardene to relieve coronary spasm.

Mr. Kilgore developed hemoptysis on January 6, 2002 and went to Central Baptist Hospital. (DX 50-368) Dr. Bassam Khalil followed him, and Dr. Scott Pierce wrote a consult report, noting Mr. Kilgore's smoking history and his industrial exposure consistent with coal miner's pneumoconiosis. (DX 50-368) Mr. Kilgore had significant pain in his left chest that radiated to his right chest and up his neck. A CT scan showed a left hilar mass. He underwent a bronchoscopy on January 11, 2002, which was nondiagnostic; a fine needle aspiration led to a diagnosis of small cell lung cancer. (DX 50-626)

On January 11, 2002, Mr. Kilgore underwent a bronchoscopy. (DX 50-643) Three specimens were retrieved and examined by Dr. Terry D. Clark. The first specimen consisted of predominantly oral material and was negative for malignant cells. The second specimen consisted of bronchial cells and pulmonary macrophages; Dr. Clark found no evidence of malignancy. The last specimen consisted of many histiocytes and columnar respiratory epithelial cells.

Dr. Dubilier examined the specimen retrieved during Mr. Kilgore's needle aspiration biopsy of his left hilar mass on January 11, 2002, performed by Dr. Nelson T. Rice. (DX 21, 50-374) Dr. Dubilier found blood intermixed with isolated and small variably sized groups of small

cell carcinoma, with a nuclear size of lymphocytes with smudged nuclear chromatin and ill-defined cytoplasm.

Dr. Clark examined the specimens retrieved during Mr. Kilgore's bronchoscopy on January 11, 2002, performed by Dr. Bassam Khalil. (DX 50-629, 50-643-45) He found no intrinsic pathology, but noted oral material, bronchial cells, pulmonary macrophages, histiocytes, and columnar respiratory cells. Overall, the bronchoscopy specimens were negative for malignancy.

Dr. Khalil reported Mr. Kilgore's industrial exposure to coal dust, and his history of coronary atherosclerotic disease and left stent placement, as well as gastroesophageal reflux and hypercholesterolemia. He was aware of Mr. Kilgore's smoking history. On physical examination, Mr. Kilgore's lungs were relatively clear with a little bit of decreased breath sounds on the left versus the right. Mr. Kilgore's preliminary pathology report showed small cell lung cancer. Dr. Khalil indicated that small cell carcinoma was the final diagnosis for Mr. Kilgore's left hilar mass. (DX 50-632)

Our Lady of the Way Hospital (OLWH)

Dr. Savolaine interpreted an x-ray performed on September 1, 2000, noting some chronic interstitial changes. (DX 53)

On September 11, 2000, Dr. Kumar performed an echocardiogram in response to Mr. Kilgore's complaints of chest pain. (DX 53) He found the test to be adequate and Mr. Kilgore's left ventricular function to be normal.

On September 25, 2001, Dr. Kumar performed a cardiolite stress test in response to Mr. Kilgore's complaints of chest pain and coronary artery disease. (DX 53) Dr. Kumar concluded that Mr. Kilgore had a normal EKG response to Persantine infusion. He saw no evidence for inducible ischemia, indicating that the scan was normal, as was the left ventricular function.

On January 9, 2002, Mr. Kilgore went to OLWH for a chest x-ray. (DX 53) This film, according to Dr. Sola, revealed COPD, atelectasis, and an infiltrative process in the left lower lobe. A fullness in the left hila region suggested a mass. Dr. Sola also took a CT scan on January 9, 2002, which showed bilateral pleural fluid in the dependent portion of the lungs, an infiltrate in the right lung not seen on plain films, an infiltrate in the left mid lung, and fullness and mass density in the left hilum.

A chest x-ray taken at OLWH on August 13, 2002 and interpreted by Dr. Sola showed a mass in the region of the left hilum suggestive of bronchogenic carcinoma.

Dr. Kumar performed an echocardiograph on November 27, 2002. (DX 53) He found a moderate reduction in the left ventricular systolic function, diastolic dysfunction of the left ventricle, mild mitral regurgitation, mild tricuspid regurgitation, upper normal size of the aortic root, and diffuse hypokinesis of the left ventricle.

Mr. Kilgore was admitted to Our Lady of the Way Hospital on January 16, 2003 for treatment of lung cancer and pneumonia. (DX 50-200) He complained of right sided chest pain, and was followed by Dr. Prem Verma, who ordered a chest x-ray and CT scan, which showed that Mr. Kilgore's left hilar mass had tripled in size. He had also developed obstructive atelectasis in the left upper lobe. Dr. Sola noted obstructive pneumonia adjacent to the left hilar mass. Physical examination revealed rales and rhonchi on the left side of the chest. Dr. Verma

consulted Dr. Kumar, and they put Mr. Kilgore on two liters of oxygen per minute, injected medications and started him on IV fluids. An echocardiogram revealed a mild reduction in the left ventricular systolic function, and inferobasal hypokinesis. Mr. Kilgore's shortness of breath decreased; he was instructed to follow up as needed.

Mr. Kilgore returned to Our Lady of the Way on February 3, 2003 and was admitted for treatment of shortness of breath, altered mental sensorium, and decreased urine output. (DX 50-264) He was followed by Dr. Kumar. On physical examination, Mr. Kilgore had bronchial breath sounds on the left and normal breath sounds on the right. His abdomen was mildly distended. Dr. Kumar diagnosed dehydration, hypotension with tachycardia, and neutropenia with depleted platelet count. He also diagnosed lung cancer.

On March 7, 2003, Mr. Kilgore was readmitted to Our Lady of the Way Hospital. (DX 50-311) Dr. Terry Wright was the attending physician; he noted Mr. Kilgore's history of lung cancer. Mr. Kilgore presented complaining of shortness of breath, made worse with exertion. On physical examination, Mr. Kilgore had a non-productive cough. His pulmonary examination revealed mild respiratory distress with wheezing bilaterally. Dr. Wright obtained a chest x-ray, which revealed significant changes of chronic obstructive pulmonary disease, severe bullae in the lower lobes, thickened fissures, and a left hilar mass with adjacent areas of small, patchy, hazy opacities which could be related to an obstructive pneumonia. Dr. Wright gave Mr. Kilgore SoluMedrol for his shortness of breath, which seemed to help. During his stay, Mr. Kilgore became increasingly more agitated and was given increasing doses of Morphine for his complaints of pain. He died at 10:10 p.m. on March 11, 2003.

Dr. Wright completed Mr. Kilgore's death certificate. (DX 50-363) He listed metastatic carcinoma as the cause of death, secondary to oat cell carcinoma of the lung.

Kentucky Cardiovascular Group

On November 25, 1998, Mr. Kilgore went to the Kentucky Cardiovascular Group for an examination. (DX 50-458) Dr. Avichai Eres performed a stress echocardiogram, during which Mr. Kilgore experienced some chest discomfort and lateral and apical wall ischemia. Physical examination revealed normal cardiac and pulmonary functions. Dr. Eres diagnosed angina, tobacco use, and hypercholesterolemia. He recommended a left heart catheterization and encouraged smoking cessation.

Highlands Regional Medical Center (HRMC)

Mr. Kilgore was admitted to HRMC on December 31, 1982 for septicemia and severe upper respiratory infection. (DX 50) He was followed by Dr. Robert Roe. Mr. Kilgore presented with fever, chills and sore throat. His chest x-ray was normal, but his white blood cell count, hemoglobin and hematocrit were elevated. He was admitted and placed on IV fluids and medications. Dr. Syed Akhtar saw him and recommended ruling out pneumococcal bacteremia. Mr. Kilgore responded well and was able to go home on January 4, 1983 in a much improved condition.

DISCUSSION

Change in Condition of Entitlement

The instant claim is a "duplicative" or "subsequent" claim because a prior claim was finally denied over one year ago. There is, accordingly, a threshold issue as to whether there are

grounds for reopening the claim under 20 C.F.R. §725.309. A subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present.[4] 20 C.F.R. §§725.309(d)(2), (3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. §725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement. In making that determination, I must also consider whether the newly submitted evidence differs "qualitatively" from the evidence submitted during the previously adjudicated claim. *Sharondale Corp. v. Ross*, 42 F.3d 993, 999, 19 BLR 2-10 (6th Cir. 1994).

Mr. Kilgore's previous living miner's claim was finally because he did not establish the existence of pneumoconiosis or total disability due to pneumoconiosis. (DX 1) Thus, for purposes of adjudicating the "subsequent" claim, I must first evaluate whether the Claimant has established either of these elements of entitlement by a preponderance of the newly submitted evidence.

Existence of Pneumoconiosis

Section § 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. In this case, the record contains twenty-three interpretations of twenty x-rays, most of which were performed while Mr. Kilgore was hospitalized in connection with his treatment for lung cancer, and reflect that his physicians were following a mass in his lungs that was determined to be cancerous. After reviewing the extensive hospital and treatment records, I find that these x-rays were read for reasons unrelated to the diagnosis of the existence of pneumoconiosis. Rather, they were read in conjunction with Mr. Kilgore's diagnosis and treatment for lung cancer. Thus, I find that these x-rays are not in substantial compliance with the quality standards of 20 C.F.R. § 718.102, as they do not reliably address the presence or absence of pneumoconiosis.[5]

Indeed, of the numerous x-rays and interpretations in the record, only two were performed for the purpose of assessing the presence or absence of pneumoconiosis. Thus, Mr. Kilgore's April 17, 2001 x-ray was interpreted by three physicians, each of whom completed ILO forms. Dr. Potter and Dr. Sundaram, for whom no qualifications were provided, read the x-ray as positive for pneumoconiosis. However, Dr. Halbert, who is dually qualified, interpreted this x-ray as negative.

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[4] For a miner, the conditions of entitlement include whether the individual (1) is a miner as defined in this section; (2) has met the requirements for entitlement to benefits by establishing pneumoconiosis, its causal relationship to coal mine employment, total disability, and contribution by the pneumoconiosis to the total disability; and (3) has filed a claim for benefits in accordance with this part. 20 C.F.R. §725.202(d) (*Conditions of entitlement: miner*).

[5] The regulations provide that 'no chest X-ray shall constitute evidence of the presence or absence of pneumoconiosis unless it is conducted and reported in accordance with the requirements of (§718.102) and Appendix A.' 20 C.F.R. §718.102(c) (2001). In its comments to the amended regulations, the Department states that 'substantial compliance' with the quality standards for chest x-rays requires compliance with the ILO-UICC classification system.

Dr. Westerfield, who is a B reader, interpreted Mr. Kilgore's August 16, 2001 x-ray as positive for pneumoconiosis; Dr. Wicker interpreted Mr. Kilgore's June 11, 2001 x-ray as positive for pneumoconiosis.

Thus, of the physicians who provided ILO interpretations, Dr. Halbert has the superior qualifications. However, x-rays performed after that date were interpreted as positive, with one of those physicians being a B reader. Relying on these interpretations of the most recent x-rays, I find that the Claimant has established that Mr. Kilgore had pneumoconiosis by a preponderance of the x-ray evidence.

Under § 718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. Mr. Kilgore underwent a bronchoscopy, which was non-diagnostic. A second procedure, a needle biopsy of a mass in Mr. Kilgore's left lung, produced no findings consistent with pneumoconiosis; Dr. Dubilier, the examining pathologist, found that the specimen showed small cell carcinoma. Thus, I find that the Claimant has not established the existence of pneumoconiosis pursuant to § 718.202(a)(2).

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of § 718.305 does not apply to claims filed after January 1, 1982. Section 718.306 does not apply to claims where the miner died after March 1, 1978. Section 718.304 allows a presumption of complicated pneumoconiosis where, *inter alia*, an x-ray "yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C" if such miner is suffering or suffered from a chronic dust disease of the lung. 20 C.F.R. § 718.304(a). However, if the employer can affirmatively show the opacity is something other than pneumoconiosis, the x-ray loses force, and the claimant loses the benefit of the presumption. *See Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 256 (4th Cir. 2000).

Mr. Kilgore's January 21, 2002 x-ray showed a 5.5 centimeter mass in his right lower lobe. But there is no indication that this mass would be classified as Category A, B, or C under the ILO classification system. Moreover, the biopsy of January 11, 2002 conclusively established that this mass was malignant, with features consistent with small cell carcinoma. (DX 21) I find that the biopsy report affirmatively establishes that this mass is the result of Mr. Kilgore's carcinoma, not pneumoconiosis. Accordingly, the Claimant has not established the existence of pneumoconiosis by virtue of § 718.202(a)(3).

Under § 718.202(a)(4), the Claimant can also establish that Mr. Kilgore suffered from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.,* 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See,* 20 C.F.R. § 718.107, *Hoffman v. B&G Construction Co.,* 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.,* 7 B.L.R. 1-295 (1984). A report which is better supported by the objective medical evidence of record may be accorded greater probative value. *Minnich v. Pagnotti Enterprises, Inc.,* 9 B.L.R. 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP,*8 B.L.R. 1-139 (1985).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra.* Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as

the finder of fact to decide. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP,* 11 B.L.R. 1-135 (1988). An equivocal opinion, however, may be given little weight. *Justice v. Island Creek Coal Co.,* 11 B.L.R. 1-91 (1988); *Snorton v. Zeigler Coal Co.,* 9 B.L.R. 1-106 (1986).

In this case, Dr. Sundaram diagnosed pneumoconiosis, based on his clinical examination of Mr. Kilgore, as well as the results of his x-ray, pulmonary function test and arterial blood gas studies. I find that his opinion is well reasoned and supported by the objective medical evidence.

Dr. Wicker read Mr. Kilgore's chest x-ray, and classified it as positive, category 1/1. However, in his report he stated that he saw no evidence of pneumoconiosis. (DX 16) He also responded in the negative when asked if Mr. Kilgore had an occupational lung disease caused by coal mine employment. Dr. Wicker provided no explanation for these inconsistent findings, and I find that his opinion is of little, if any assistance in determining if the medical opinion evidence establishes the existence of pneumoconiosis.

Dr. Puram, one of Mr. Kilgore's treating physicians, diagnosed coal workers' pneumoconiosis. But he did not indicate the basis for this diagnosis; indeed, the only apparent basis for this opinion is Mr. Kilgore's report that he had coal workers' pneumoconiosis. I find that Dr. Puram's opinion is not based on objective medical evidence, and I do not find it persuasive.

Dr. Westerfield, who is board-certified in internal and pulmonary medicine, diagnosed pneumoconiosis, based on the x-ray evidence of record and Mr. Kilgore's extensive history of coal dust exposure. As his opinion is based on objective medical evidence, I find Dr. Westerfield's opinion to be well-reasoned and supported by the evidence of record.

Extensive medical records from Mr. Kilgore's treatment for lung cancer have also been submitted. None of the physicians who examined or treated Mr. Kilgore at HRMC or OLWH mentioned pneumoconiosis; the records focus on Mr. Kilgore's treatment for pneumonia and lung cancer. Dr. Wright, at PMH, included coal workers' pneumoconiosis in his diagnosis; but his report contains no rationale or objective support for this diagnosis other than Mr. Kilgore's report that he had black lung. Other than as discussed above, Dr. Puram's treatment records did not discuss coal workers' pneumoconiosis; nor did any physician attribute Mr. Kilgore's other lung conditions to his exposure to coal dust. I find that the hospital records, which reflect that Mr. Kilgore's physicians were focused on the treatment of his lung cancer, are inconclusive, and do not establish that Mr. Kilgore had pneumoconiosis or any respiratory impairment related to exposure to coal dust.

However, weighing all of the medical opinion evidence together, I find that the Claimant has established that Mr. Kilgore had pneumoconiosis, by virtue of the reports from Dr. Sundaram and Dr. Westerfield, who specifically addressed the issue of pneumoconiosis, and whose opinions are well-reasoned and consistent with the medical evidence in the record. They diagnosed pneumoconiosis after performing thorough examination and testing and, in the case of Dr. Westerfield, reviewing Mr. Kilgore's medical records. I find that the Claimant has established by a preponderance of the medical opinion evidence that Mr. Kilgore had pneumoconiosis.

The record also contains 12 CT scan interpretations describing abnormalities in Mr. Kilgore's lungs, abdomen and liver. None of the interpreting physicians attributed any abnormalities to coal dust exposure. Instead, the interpretations focused on the progress of Mr. Kilgore's left lung mass.

Finally, I have weighed all of the evidence under § 718.202(a) together, including the x-ray evidence, and I find that the Claimant has met her burden to establish that Mr. Kilgore had pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000).

Because the Claimant has established that Mr. Kilgore had pneumoconiosis she has established a material change in Mr. Kilgore's condition. As a result, the Claimant is entitled to a consideration of Mr. Kilgore's claim on the merits.

Merits of the Claim

Establishment of Pneumoconiosis

In his previous claim, which was denied by Administrative Law Judge Gilday on May 3, 1993, there were twenty two interpretations of seven x-rays, performed over a thirteen month period in 1991 and 1992. Eighteen of these interpretations were negative, and four were positive for pneumoconiosis. As Judge Gilday noted, the preponderance of the x-ray interpretations by the most qualified physicians was negative for pneumoconiosis.

However, approximately nine years passed between the x-rays considered by Judge Gilday, and the ILO interpretations submitted in connection with this subsequent claim. The Board has held that pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 BLR 1-451 (1984). Examining all of the x-ray evidence as a whole, and taking into account that pneumoconiosis is a progressive condition, I find that the Claimant has established that Mr. Kilgore had pneumoconiosis on the basis of x-ray evidence.

Mr. Kilgore did not submit any biopsy evidence in conjunction with his previous claim.

Judge Gilday also reviewed nine medical opinion reports in his 1993 Decision and Order. Thus, Dr. Fritzhand, Dr. Dahhan, and Dr. Vuskovich examined Mr. Kilgore and administered testing, but they did not find evidence of pneumoconiosis. Dr. Fritzhand concluded that Mr. Kilgore had chronic obstructive pulmonary disease due to his cigarette smoking, while Dr. Dahhan and Dr. Vuskovich concluded that he had chronic bronchitis due to his cigarette smoking. On the other hand, Dr. Anderson, Dr. Myers, and Dr. Potter each found that Mr. Kilgore had pneumoconiosis, on the basis of a positive x-ray.

Dr. Broudy and Dr. Lane reviewed Mr. Kilgore's medical records, concluding that there was not sufficient evidence of pneumoconiosis, or any pulmonary disability due to coal dust exposure. Dr. Branscomb, who also reviewed the records, concluded that Mr. Kilgore had no respiratory impairment due to his coal dust exposure, but that he had mild chronic obstructive pulmonary disease due to his cigarette smoking.

I agree with Judge Gilday that, while the opinions of the examining physicians are equally balanced, the opinions of Dr. Broudy, Dr. Lane, and Dr. Branscomb, who reviewed all of the available medical evidence, that Mr. Kilgore's non-disabling pulmonary impairment Mr. Kilgore had was not related to his exposure to coal dust, is entitled to substantial weight.

Relying on those opinions, I find that the medical opinion evidence in the previous claim did not establish the existence of pneumoconiosis.

However, as with the x-ray evidence, I note that many years have passed between the time these opinions were submitted, and the time the current opinions were prepared. The physicians who submitted the most recent reports had access to updated medical information, including new x-rays. Given that pneumoconiosis is a progressive condition, I give determinative weight to the opinions of Dr. Sundaram and Dr. Westerfield, and find that the Claimant has established that Mr. Kilgore had pneumoconiosis by a preponderance of the persuasive medical opinion evidence.

Total Disability

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. § 718.204(b)(1).

Total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right-sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment. 20 C.F.R. § 718.204(b)(2). Furthermore, under 20 C.F.R. § 718.304, if a claimant can establish the existence of "complicated pneumoconiosis," an irrebuttable presumption arises that the claimant is totally disabled due to pneumoconiosis. For a living miner's claim, total disability may not be established solely by the miner's testimony or statements. 20 C.F.R. § 718.204(d)(5).

Pulmonary Function Tests

Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary functions tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. 718, **and either** the FVC has to be equal to or less than the value in Table B3, or the MVV has to be equal or less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%. Should more than one ventilatory study be presented, more weight may be accorded to the results of a recent ventilatory study over the results of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993). I must also determine the reliability of a study based upon its conformity to quality standards and consider medical opinions of record regarding a study's reliability. *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986).

In this case, a total of seven pulmonary function tests are in the record,[6] six of which do not meet the standards under the regulations to qualify for disability. The most recent test, taken January 11, 2002, produced results that qualify for disability. However, I find that the reliability of these results is called into question by Dr. Westerfield, who reviewed the results and determined that there were not three spirometry maneuvers, with the best two scores not being

[6] Four tests were submitted in conjunction with the current claim, three with Mr. Kilgore's previous claim.

within a 5% variability as required by the American Thoracic Society. I find the Claimant has not established that Mr. Kilgore was totally disabled based on the pulmonary function test results.

Arterial Blood Gas Studies

To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO2 level, the value of the coal miner's pO2 must be equal to or less than the corresponding pO2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. 718. The Board has held that more weight may be given to the results of a recent blood gas study over a study that was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

The record includes six arterial blood gas studies,[7] the most recent of which qualifies for total disability. I find that this test is the most reliable indicator of Mr. Kilgore's pulmonary condition, and accordingly, I find that the Claimant has established that, absent contrary probative evidence, Mr. Kilgore was totally disabled, by virtue of the arterial blood gas study evidence.

Medical Opinion Evidence

In connection with the current claim, Dr. Sundaram believed that Mr. Kilgore was totally disabled, stating that he could not perform his last coal mining job or any comparable job in a dust free environment. On the other hand, Dr. Wicker found no respiratory impairment during his June 11, 2001 examination of Mr. Kilgore, and determined that Mr. Kilgore's respiratory condition was sufficient to allow him to return to coal mine employment.

Dr. Westerfield found no respiratory impairment on his examination of Mr. Kilgore, but in his review of the medical records, he noted a decrease in lung function on later pulmonary tests. At the time of his examination of Mr. Kilgore, Dr. Westerfield concluded that he could perform his last coal mining job; but he did not indicate whether the later pulmonary function studies that he reviewed reflected the development of a disabling respiratory impairment.

Dr. Puram did not provide an opinion on whether Mr. Kilgore was totally disabled; his records focus on the progression and treatment of Mr. Kilgore's lung cancer. In connection with the previous claim, only one of the nine physicians who examined Mr. Kilgore or reviewed his medical records concluded that he had a disabling lung condition. Thus, Dr. Martin Fritzhand concluded that Mr. Kilgore could not perform his previous coal mining work, but he attributed his disability to his cigarette smoking.

As discussed above, Mr. Kilgore's hospital treatment records are focused on his treatment for lung cancer; they do not discuss his level of respiratory impairment.

Considering the medical reports as a whole, I find that while they are not sufficient, standing alone, to establish that Mr. Kilgore had a totally disabling respiratory impairment, nevertheless they do not contradict the presumption of total respiratory disability afforded by the qualifying arterial blood gas results. Accordingly, I find that the Claimant has established that Mr. Kilgore had a totally disabling respiratory impairment.

But the Claimant still must establish that Mr. Kilgore was totally disabled *due to* pneumoconiosis. In this regard, Dr. Sundaram concluded that Mr. Kilgore's totally disabling

[7] Three studies were submitted in conjunction with the current claim, three with Mr. Kilgore's previous claim.

respiratory disability was due to coal dust exposure. But he provided no rationale or support for this conclusion, nor did he even address Mr. Kilgore's development of lung cancer, or his long history of cigarette smoking. I find that Dr. Sundaram's opinion is entitled to little weight.

Dr. Westerfield attributed Mr. Kilgore's decrease in lung function to either his lung cancer or his treatment for lung cancer. He pointed to the progression of Mr. Kilgore's cancer between the time of the non-qualifying pulmonary function and arterial blood gas tests and the qualifying pulmonary function and arterial blood gas tests to support his conclusion. I note that the qualifying test results were obtained in January 2002, which coincides with the first indication of lung cancer on Mr. Kilgore's chest x-rays. I find that Dr. Westerfield's opinion is well-reasoned and supported by the objective medical evidence, and I accord it significant weight.

In connection with the previous claim, Drs. Fritzhand, Vuskovich, Dahhan, Broudy, and Branscomb blamed cigarette smoking for Mr. Kilgore's pulmonary impairment. Dr. Lane attributed Mr. Kilgore's mild impairment to heart disease, not coal dust exposure.

Drs. Wicker, Puram, Anderson and Myers did not indicate an etiology for any disability; Dr. Potter did not address the issue of disability at all.

Considering all of the evidence as a whole, I find that the Claimant has not established by a preponderance of the evidence that Mr. Kilgore's totally disabling respiratory impairment was due to pneumoconiosis. Rather, the overwhelming weight of the reliable medical evidence is consistent with the development of impairment in conjunction with the progression of Mr. Kilgore's lung cancer.

As the Claimant has not established that Mr. Kilgore's totally disabling respiratory impairment was due to pneumoconiosis, she is not entitled to benefits under the Act in Mr. Kilgore's living miner's claim

.Survivor's Claim

X-ray Evidence

The Claimant's evidence summary for the survivor's claim lists only the interpretation by Dr. Sola of a January 9, 2002 x-ray as her initial x-ray evidence. Dr. Sola indicated that this x-ray showed "changes of COPD." However, the Claimant also listed Mr. Kilgore's hospital treatment records, as summarized above, which include numerous x-ray interpretations.

In its evidence summary form, the Employer designated the interpretation by Dr. Westerfield of the August 16, 2001 x-ray (DX 41/52); Dr. Westerfield read this film as 1/1. As rebuttal, the Employer designated Dr. Halbert's negative reading of the April 17, 2001 x-ray. However, the Claimant has not designated any readings of this x-ray on her evidence summary form, nor were these interpretations part of hospitalization or treatment records. As there is no interpretation of the April 17, 2001 x-ray to rebut, I have not considered Dr. Halbert's interpretation of that x-ray.

As discussed above, the numerous x-rays and CT scans performed while Mr. Kilgore was hospitalized were done for the purpose of assessing and treating his lung cancer, not to determine if he had pneumoconiosis, and thus they are of no assistance in determining if Mr. Kilgore had pneumoconiosis.

Pulmonary Function Tests

The Claimant did not designate any pulmonary function studies in connection with her survivor's claim, and the treatment and hospitalization records do not include any studies. The Employer designated the August 16, 2001 study by Dr. Westerfield, which did not produce qualifying results.[8]

Arterial Blood Gas Studies

Again, the Claimant did not designated any arterial blood gas studies in connection with her survivor's claim, nor are any tests included in the hospitalization or treatment records. The Employer designated Dr. Westerfield's August 16, 2001 study, which produced normal results.

Medical Opinions

In addition to the hospitalization and treatment records summarized earlier, the Claimant submitted or specifically designated the following reports in connection with her survivor's claim.

Dr. Firas Koura

Dr. Firas A. Koura, who is a pulmonologist, wrote a letter to the Claimant's attorney, dated January 4, 2005, after he reviewed Mr. Kilgore's medical records. (CX 3) Dr. Koura stated that, based on Mr. Kilgore's exposure to coal dust and Dr. Westerfield's x-ray interpretation, the records established a diagnosis of pneumoconiosis. He stated that the cause of Mr. Kilgore's death was lung cancer, "but the presence of the CWP diagnoses would have worsened the patient's condition and would be a contributing factor in causing Mr. Kilgore's death."

Dr. Ananth Kumar

Dr. Kumar wrote a report after treating Mr. Kilgore at OLWH on February 3, 2003. Mr. Kilgore was admitted for shortness of breath, altered mental sensorium, and decreased urine output. (DX 50-264)

On physical examination, Mr. Kilgore's bronchial breath sounds were present on the left and normal on the right. His abdomen was mildly distended. Dr. Kumar diagnosed dehydration, hypotension with tachycardia, and neutropenia with depleted platelet count. He also diagnosed terminal lung cancer; Mr. Kilgore's prognosis was poor.

The Employer relies on the report by Dr. Westerfield, which I described earlier, as well as a report from Dr. Broudy.

Dr. Bruce C. Broudy

Dr. Broudy, who is board-certified in internal and pulmonary medicine and a NIOSH B-reader, reviewed Mr. Kilgore's medical records at the Employer's request, and wrote a report dated July 26, 2004. (DX 53A) He also testified by deposition on June 10, 2005.

Dr. Broudy stated that Mr. Kilgore was diagnosed with metastatic small cell carcinoma of the lung following a needle aspiration biopsy of a left hilar mass on January 11, 2002. A CT scan of the abdomen confirmed multiple liver metastases. Doctors treated Mr. Kilgore with

[8] The Employer also designated as rebuttal evidence the deposition testimony by Dr. Westerfield that studies performed by Dr. Sundaram and Dr. Puram were not valid. However, these two studies are not in the record for purposes of the survivor's claim.

chemotherapy, but he never went into full remission. After developing septicemia, Mr. Kilgore was hospitalized approximately one month before his death.

Dr. Broudy summarized the x-ray interpretations of other physicians, and noted Mr. Kilgore's smoking history of 30 pack years. Mr. Kilgore's work history included 14-17 years on surface mining operations.

In Dr. Broudy's opinion, the evidence did not support the conclusion that Mr. Kilgore had pneumoconiosis or any other disease process caused by coal dust exposure. But Dr. Broudy believed that even if Mr. Kilgore had pneumoconiosis or a coal dust related disease at the time of his death, it played no role in causing, contributing to, or hastening by any degree his death, aggravating his lung cancer, or affecting his response to chemotherapy treatment. Dr. Broudy pointed to Mr. Kilgore's normal lung function before his diagnosis of lung cancer as support for the unlikelihood of coal mine dust playing any role in his death.

Biopsy Evidence

I have summarized the biopsy evidence above, and I incorporate that summary by reference.

Death Certificate

Dr. Terry Wright completed Mr. Kilgore's death certificate. (DX 46) Mr. Kilgore died on March 11, 2003. Dr. Wright listed metastatic carcinoma as the immediate cause of death, secondary to oat cell carcinoma of the lung.

Hospitalization and Treatment Records

Mr. Kilgore's hospitalization and treatment records have been summarized in his living miner's claim above. I incorporate those summaries herein.

DISCUSSION

Standard

The Regulations at 20 C.F.R. § 718 apply to survivors' claims which are filed on or after April 1, 1982. 20 C.F.R. § 718.1. Because the Claimant filed her survivor's claim after January 1, 1982, 20 C.F.R. § 718.205 applies to this claim.

The regulations provide that a survivor is entitled to benefits only where the miner died due to pneumoconiosis. 20 C.F.R. § 718.205(a). The Claimant must establish that: (1) the decedent was a coal miner; (2) the decedent suffered from pneumoconiosis at the time of his death; (3) the decedent's pneumoconiosis arose out of his coal mine employment; and (4) the decedent's death was caused by pneumoconiosis or pneumoconiosis was a substantially contributing cause or factor leading to his death. All elements must be established by a preponderance of the evidence. *Strike v. Director, OWCP,* 817 F.2d 395, 399 (7th Cir. 1987). The survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. 718.205 (c). If the principal cause of death is a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. 718.205 (c)(4).

The Board has held that death will be considered to be due to pneumoconiosis where the cause of death is significantly related to or significantly aggravated by pneumoconiosis. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371 (1985). The United States Court of Appeals for the Fourth Circuit, in which the instant case arises, has held that pneumoconiosis is a substantially contributing cause of death if it hastens, even briefly, the miner's death. *See, Shuff v. Cedar Coal Co.,* 967 F.2d 977 (4th Cir. 1992), *cert. denied,* 113 S.Ct. 969 (1993). *See also, Brown v. Rock Creek Mining Corp.,* 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting); *Peabody Coal Co. V. Director, OWCP,* 972 F.2d 178 (7th Cir. 1992); *Lukosevicz v. Director, OWCP,* 888 F.2d 1001 (3rd. Cir. 1989). Here, Employer challenges whether Mr. Kilgore had pneumoconiosis and whether his death was caused by pneumoconiosis.

Establishment of Pneumoconiosis

Dr. Sola, whose qualifications are unknown, read a chest x-ray and CT scan dated January 9, 2002, but did not make findings of pneumoconiosis. Dr. Westerfield, who is a B reader, classified his ILO reading of Mr. Kilgore's August 16, 2001 x-ray as positive for pneumoconiosis. Relying on the interpretation by the B reader, I find that the x-ray evidence in the survivor's claim establishes that Mr. Kilgore had pneumoconiosis.

In this case, no autopsy was performed on Mr. Kilgore. The bronchoscopy performed by Dr. Khalil was nondiagnostic, and the January 11, 2002 needle biopsy resulted in a diagnosis of small cell carcinoma, not pneumoconiosis. (DX 21) Thus, I find that Claimant has not established the existence of pneumoconiosis pursuant to § 718.202(a)(2).

As discussed in Mr. Kilgore's living miner's claim, none of the presumptions afforded by § 718.202(a)(3) apply.

Dr. Koura reviewed Mr. Kilgore's medical records, and diagnosed pneumoconiosis, based on Mr. Kilgore's history of coal dust exposure and the positive x-ray interpretation by Dr. Westerfield. It is not clear what records Dr. Koura reviewed; his brief, summary opinion appears to be merely a restatement of Dr. Westerfield's conclusions. Dr. Koura did not discuss the development of Mr. Kilgore's lung cancer, or the effect of his cigarette smoking. I find that Dr. Koura's brief opinion is not well-documented or supported by any persuasive rationale, and I accord it little weight.

Dr. Kumar did not mention pneumoconiosis in his report, which I find to be of no assistance in determining if Mr. Kilgore had pneumoconiosis.

As discussed in Mr. Kilgore's living miner's claim, Dr. Westerfield diagnosed pneumoconiosis, based on the x-ray evidence of record and Mr. Kilgore's history of coal dust exposure, as well as his examination of Mr. Kilgore and the results of objective studies. His reliance on the x-ray evidence is based on objective medical evidence and is in accordance with my findings. I also find Dr. Westerfield's opinion to be well-reasoned, as he considered all potential causes of the abnormalities found on Mr. Kilgore's x-ray film, and I find that his opinion is entitled to significant weight.

Dr. Broudy determined that the medical records and x-ray evidence did not support a diagnosis of pneumoconiosis. However, I have determined that the x-ray evidence does establish pneumoconiosis. Although both Dr. Broudy and Dr. Westerfield have impressive credentials, I credit the opinion of Dr. Westerfield, who examined Mr. Kilgore, and whose conclusions on the x-ray evidence are in accord with mine.

As discussed above, the hospitalization and treatment records are inconclusive on the question of whether Mr. Kilgore had pneumoconiosis, or any pulmonary impairment related to coal dust exposure. Nor do the CT scans address this issue. Dr. Wright, who completed the death certificate, did not mention pneumoconiosis.

Weighing all of the evidence together, and giving significant weight to Dr. Westerfield's opinion, I find the Claimant has established that Mr. Kilgore had pneumoconiosis on the basis of x-ray and medical opinion evidence.[9]

Death Due to Pneumoconiosis

To be entitled to benefits, the Claimant still must establish that her husband's death was due to pneumoconiosis. Since the claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by § 718.205(c), as amended, which states, in pertinent part:

> For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> (1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> (3) Where the presumption set forth at § 718.304 is applicable.
>
> (4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.
>
> (5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

20 C.F.R. § 718.205(c).

In this case, two physicians have indicated that Mr. Kilgore's death was due to pneumoconiosis. Thus, in his January 4, 2005 letter, Dr. Kuora stated that while the reported cause of Mr. Kilgore's death was lung cancer, the presence of coal workers' pneumoconiosis "would have worsened the patient's condition and would be a contributing factor in causing Mr. Kilgore's death." (CX 3) Again, however, there is no indication that Dr. Kuora ever treated Mr. Kilgore, nor did he specify which of his medical records he reviewed. He did not provide any rationale or support for his bald conclusion, nor did he explain how pneumoconiosis would have worsened Mr. Kilgore's condition. In addition, I find his comments to be speculative. I accord Dr. Kuora's opinion little weight.

Although the evidence in Mr. Kilgore's living miner's claim includes a letter from Dr. Sundaram, dated March 19, 2003, the Claimant did not designate this letter on her Evidence Summary Form. As such, I cannot consider this letter in my determination of the cause of Mr. Kilgore's death because the Claimant has met her limitations on medical report submissions and Dr. Sundaram's report is not linked to any treatment records.

[9] As the Claimant has established that Mr. Kilgore worked in coal mines for at least ten years, she is entitled to the presumption that Mr. Kilgore's pneumoconiosis arose out of his coal mine employment. 20 C.F.R. § 718.203(b).

But even if I were to consider Dr. Sundaram's report, I find that it is not sufficient to establish that Mr. Kilgore's death was related to pneumoconiosis. Dr. Sundaram indicated that he treated Mr. Kilgore, and that Mr. Kilgore was "later" diagnosed with lung cancer. It does not appear that Dr. Sundaram treated Mr. Kilgore in the years just before his death, nor does Dr. Sundaram's name appear in any of the hospitalization records. In short, it does not appear that Dr. Sundaram had any familiarity with Mr. Kilgore's medical condition for some time before his death. Nor did Dr. Sundaram offer any basis for his statement that Mr. Kilgore's exposure to coal dust in part caused his death. I find his opinion to be wholly unsupported by any rationale or objective medical evidence, and I accord it little, if any weight.

In contrast, Dr. Broudy concluded that Mr. Kilgore's death was unrelated to coal dust exposure. He pointed to Mr. Kilgore's normal pulmonary function test results as late as 12 years after his last exposure to coal mine dust, concluding that it was "extremely unlikely" that coal workers' pneumoconiosis or coal mine dust exposure played any role in Mr. Kilgore's death or contributed to any disability or impairment. (DX 53-A) I find that Dr. Broudy's opinion is well-reasoned, and supported by the objective medical evidence. I accord his opinion significant weight.

The hospitalization records reflect that Dr. Wright treated Mr. Kilgore during his final hospitalization. Dr. Wright listed metastatic carcinoma as the cause of Mr. Kilgore's death, secondary to oat cell carcinoma of the lung. He did not mention pneumoconiosis or coal dust exposure as a factor in Mr. Kilgore's death.

After reviewing all of the admissible evidence, I find the Claimant has not established by a preponderance of the evidence that pneumoconiosis was a contributing cause, substantially or otherwise, to Mr. Kilgore's death.

CONCLUSION

Although the record shows Mr. Kilgore worked in coal mine employment for at least 10 years and that he had pneumoconiosis, it does not establish that he was totally disabled due to pneumoconiosis, or that pneumoconiosis caused, substantially contributed to, or hastened his death. Therefore, I find that the Claimant is not entitled to benefits under the Act and applicable regulations, either in connection with Mr. Kilgore's living miner's claim, or the survivor's claim.

ATTORNEY'S FEES

The award of attorney's fees under the Act is permitted only in the cases in which the claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to her in pursuit of this claim.

ORDER

Based on the foregoing, IT IS HEREBY ORDERED that the claims of Phyllis Kilgore, surviving spouse of Gary Kilgore, for black lung benefits under the Act are **DENIED**.

A

LINDA S. CHAPMAN

Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S.

Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).